Department of HUMAN SERVICES

Ground Emergency Medical Transportation (GEMT) Program Billing and Cost Reporting Guide

July 2019

About this Billing Guide

This billing guide takes effect July 1, 2019. The guide has been developed to assist qualified publicly owned or operated Ground Emergency Medical Transportation (GEMT) providers understand requirements necessary for reporting the claim information considered for GEMT prospective payment.

What has changed?

This is the first version of the GEMT Billing Guide.

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Definitions

Advanced Life Support (ALS) – Special services designed to provide prehospital emergency care, including but not limited, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with other drugs and other medicinal preparations, and other specified techniques and procedures.

Agency – The Iowa Department of Human Services

Allowable Costs – An expenditure which meets the requirements under Part 413 of Title 42 of the Code of Federal Regulations, 2 C.F.R. Part 200 and Medicaid non-institutional reimbursement policy.

Basic Life Support (BLS) – Emergency first aid and cardiopulmonary resuscitation procedures to maintain life support without invasive techniques.

Cognizant Agency – The federal agency with the largest dollar value of direct federal awards with a governmental unit or component.

Cost Allocation Plan (CAP) – A document that identifies, accumulates, and distributes allowable direct and indirect costs to cost objectives. The CAP also identifies the allocation methods used for distribution to cost objectives, based on relative benefits received.

Direct Costs – All costs identified specifically with a particular final cost objective in order to meet emergent medical transportation requirements.

Direct Federal Award – An award paid directly from the federal government. GEMT is not a direct award because it is paid through the Iowa Department of Human Services.

Dry Run – A run that does not result in either a transport or a delivery on-site of Medicaid covered services.

Emergency Medical Response – Services performed at the point of injury or illness to evaluate or treat a health condition.

Emergency Response – An activity such as fire suppression and EMR, which mitigates unexpected events that threaten to harm humans or damage property.

Federal Financial Participation (FFP) – The portion of medical assistance expenditures that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) according to the state plan for medical assistance.

Federal Matching Assistance Percentage (FMAP) – The percentage rate used to determine the amount of federal matching funds received by the state for expenditures under the Medicaid program.

Ground Emergency Medical Transport – Emergency services provided by a GEMT provider to individuals, include dry runs.

Ground Emergency Medical Transportation Services – Includes both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by GEMT providers before or during the act of transportation.

Indirect Costs – Costs for a common or joint purpose benefitting more than one cost objective and allocated to each objective using an agency-approved indirect rate or an allocation methodology.

Intergovernmental Transfer (IGT) – Transfer of funds from another government entity (e.g., county, city, or another state agency) to the state Medicaid agency.

Limited-Advanced Life Support – Special services designed to provide prehospital emergency medical care limited to techniques and procedures that exceed basic lif support but are less than advanced life support services.

Prehospital Care – The assessment, stabilization, and care of a medical emergency during a medical emergency of an ill or injured patient by a paramedic or other person before the patient reaches the hospital.

Publicly Owned or Operated – A unit of government that is a state, city, county, special purpose district, or other governmental unit in the state that:

- Has direct access to tax revenues
- Has taxing authority
- Is an Indian tribe as defined in Section 4 of the Indian Self Determination and Education Assistance Act

Qualifying Expenditure – An expense for covered services provided to an eligible Medicaid member.

Service Period – The state fiscal year (SFY) beginning July 1 and ending June 30 annually.

Shared Direct Costs – Direct costs that can be allocated to two or more cost objectives on the basis of shared benefits.

Shift – A standard period of time assigned for a complete cycle of work, as set by each GEMT provider.

Uncompensated Care – Allowable cost of Medicaid services provided to patients that are not reimbursed.

About the Program

The Ground Emergency Medical Transportation (GEMT) Program is a voluntary program that allows publicly owned or operated emergency ground ambulance transportation providers to supplemental payments that cover the difference between a provider's actual costs per GEMT transport and the Medicaid base payment, mileage and other sources of reimbursement.

Providers receive cost-based, supplemental payments on a prospective basis for emergency ground ambulance transportation of Medicaid fee-for-service (FFS) and Medicaid managed care (MCO) members under Title XIX of the federal Social Security Act (SSA) and the Affordable Care Act (ACA) only.

What are the eligibility requirements for providers?

To qualify for voluntary participation under the GEMT program, providers must meet the following criteria:

- Provide GEMT services to Iowa Medicaid members.
- Be an enrolled Iowa Medicaid provider for the period being claimed.
- Be publicly owned or operated by the state, a city, a county, a fire protection district, a community services district, or federally recognized Indian tribe or any unit of government as defined in 42 CFR Sec. 433.50.

How do providers voluntary participate?

To voluntarily participate in the GEMT program as a NEW provider, submit the following by November 30 of each year:

- Submit Iowa Medicaid GEMT cost report.
- Submit signed Intergovernmental Transfer (IGT) agreement.

GEMT Prospective Supplemental Payments

The agency pays prospective GEMT supplemental payments using the IGT payment method.

- GEMT providers must submit allowable expenses determined in accordance with 2 C.F.R. Part 200 using the Iowa Medicaid GEMT cost report.

- The agency makes prospective supplemental payments for uncompensated and allowable costs incurred while providing GEMT services to Medicaid FFS and Medicaid MCO members to cover the difference between actual costs and the Medicaid base payment, mileage and other sources of reimbursement.

- If the GEMT provider does not have uncompensated care costs, the provider will not receive prospective supplemental payments under this program.
- The total prospective supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100 percent of actual costs.

- The provider will submit to the state Medicaid agency an IGT for the state share funding amount on a scheduled as defined by the agency.

GEMT Claims Submission

Providers must submit all claims for eligible services to Iowa Medicaid in a timely manner.

When submitting a claim:

- Use one of the appropriate emergency transportation procedure codes: A0225, A0427, A0429 or A0433.

- Use mileage procedure code A0425.

- Both transportation and mileage codes must be billed and paid for providers to receive GEMT prospective supplemental reimbursement.

- An additional line item entry using procedure code A0999 is required for providers to receive prospective GEMT supplemental payments. This procedure code is set to pay the provider-specific Medicaid uncompensated care cost per transport.

- Providers must bill their provider-specific Medicaid uncompensated care cost per transport rate as the submitted charge for procedure code A0999 to receive the full reimbursement. Submitted charge amounts lower than the provider-specific

Medicaid uncompensated care cost per transport amount will be reimbursed at the submitted charge amount.

GEMT Cost Reporting

All GEMT providers must annually submit direct and indirect costs as qualifying expenditures for GEMT services. Providers attest that the reported information is true and accurate to the best of their knowledge, and that the expenditures claimed have not previously been, nor will be, claimed at any other time to receive federal funds under Medicaid or any other program. Misrepresentation of information constitutes a violation of both state and federal law.

Cost reporting must:

- Be necessary to GEMT services.
- Allocate direct and indirect costs to appropriate cost objectives.
- Include personnel cost exclusive to GEMT services (fire suppression is not included).
- Be in accordance to the cost identification in the CMS Provider Reimbursement Manual and 2 C.F.R. Part 200.
- Exclude foundation grants and private fundraising because these are not expenditures of a government entity.
- Indicate average cost per transport

Formula:
Sum total of the actual allowable direct and indirect costs (**excluding dry run and runs where a Medicaid service was covered but no transport occurred**) ÷ Total number of emergency medical transports provided during the service period (**including dry runs and runs where a Medicaid service was covered but no transport occurred**)

All GEMT providers must complete an annual cost report detailing the total allowable direct and indirect costs of delivering Medicaid covered services using the approved cost allocation methodology.

Costs associated where a Medicaid covered service was delivered but no transport occurred and dry runs must be excluded from GEMT service cost.

Providers must submit to the agency an Excel version of the cost report **AND** a PDF version, including a signed and dated certification page, by November 30. The agency

considers extension requests to the cost report deadlines on a case-by-case basis. Send cost reports and extension requests to costaudit@dhs.state.ia.us.

The agency will review the cost reports and notify the provider of the status (acceptance or rejection or request for additional documentation). Providers may be asked to submit additional supporting documentation. If the cost report is rejected, the provider must make the necessary corrections and resubmit the information within 30 days of the rejection notification. Failure to provide the requested information may result in termination from the program for that reporting year.